BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against CARMELO HERRERO, M.D., Respondent.	**Case No. 10-12226-1**

FILED
JAN 08 2010
NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed at the time of approval of the filing of the instant complaint, of S. Daniel McBride, M.D. and Mr. Van Heffner, having a reasonable basis to believe that Carmelo Herreo, M.D., hereinafter referred to as Dr. Herrero, has violated the provisions of NRS Chapter 630, hereby issues its Formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Dr. Herrero is currently licensed in active status, and was so licensed by the Nevada State Board of Medical Examiners, on April 27, 1998 (License No. 8613), pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes, and at all times addressed herein was so licensed.

2. Patient A was a sixty-five year old female at the time of the occurrence at issue. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Dr. Herrero along with a copy of this Complaint.

3. Patient A was transported by emergency medical services to St. Rose Dominican Hospital, Siena Campus on December 9, 2006 after suffering three episodes of syncope while at work. She was admitted to the hospital.

4. A history and physical performed on December 10, 2006 noted Patient A reported having increased abdominal pain and diarrhea the day prior. Her medical history was notable for

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hypertension, hypothyroidism, COPD, thyroid cysts, uterine cancer and ulcerative colitis.

5. On December 11, 2006 a CT scan of Patient A's abdomen and pelvis was completed. The CT scan report noted in the transverse colon findings consistent with mild colitis and no abscesses were seen and no masses noted. The CT scan report gave an impression of mild colitis involving the transverse colon, sigmoid diverticulosis, a possible mass in the bladder and a very small amount of free fluid.

6. Dr. Herrero saw Patient A on December 12, 2006 in regard to her diarrhea and colitis. In his consultation note, Dr. Herrero noted a brief history related to Patient A's intestinal symptoms and did note she had a history of ulcerative colitis and that she had a colonoscopy performed approximately two months ago. Dr. Herrero's impression noted diarrhea and an abnormal CT scan of the abdomen suggesting a transverse colon mass, however there is no indication that he personally reviewed the CT scan.

7. Dr. Herrero suggested that a colonoscopy would be appropriate given Patient A's anemia, subacute diarrhea and her abnormal CT scan. Dr. Herrero noted that he discussed all the risks, benefits, and alternatives with Patient A, although no specific information as to what was discussed is noted. Patient A agreed to proceed forward with the colonoscopy

8. Dr. Herrero performed the colonoscopy the following day, December 13, 2006. The operative note gave an impression of mild focal colitis.

9. Subsequent to the procedure, Patient A began experiencing pain. A CT scan noted active bleeding at the spleen with a large hematoma around the spleen. Patient A was diagnosed with spontaneous splenic rupture which occurred during the colonoscopy. She underwent an emergency splenectomy on December 13, 2006.

10. Patient A was discharged from the hospital on December 22, 2006.

Count I

11. Nevada Administrative Code Section 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

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12. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

13. Dr. Herrero failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he performed a colonoscopy that was not necessary due to his failure to perform and document a thorough history and physical of Patient A and failing to review the CT scan which did not indicate a mass in the transverse colon. Accordingly Dr. Herrero is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give Dr. Herrero notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it wishes to impose for the violation or violations committed by Dr. Herrero;

4. That the Nevada State Board of Medical Examiners make, issue and serve on Dr. Herrero its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 8th day of January, 2010.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Lyn E. Beggs, Esq.
General Counsel and Attorney for the Investigative Committee

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